STATEMENT OF DEFICIENCIES X1) PROVID		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		00	COMPLETED	
			A. BUILDING		04/20/2011	
			B. WING	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R				
\/   \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		IMOOD	I -	S HWY 31 S		
VILLAGE	OAKS AT GREEN	WOOD	INDIAN	IAPOLIS, IN46227		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
R0000						
	This visit was fo	or a State Residential	R0000	This plan of correction is no	• • • • • • • • • • • • • • • • • • •	
	Licensure surve	V.		construed as an admission		
	Electistic survey.			agreement with the findings	• • • • • • • • • • • • • • • • • • •	
	Survey dates An	oril 18, 19, & 20, 2011.		conclusions in the Statemer	• • • • • • • • • • • • • • • • • • •	
	Survey dates Ap	111 10, 17, & 20, 2011.		Deficiencies, or the propose administrative penalty (with	l l	
	Facility number	. 002282		to correct) on the communit		
	1 1			Rather, it is submitted as	<b>,</b>	
	Provider numbe			confirmation of our ongoing		
	AIM number: N	/A		efforts to comply with all sta	- 1	
				and regulatory requirements	l l	
	Survey team:			this document, we have out	• • • • • • • • • • • • • • • • • • •	
	Diane Dierks, R	N, TC		specific actions in response each allegation or finding. V		
	Patti Allen, BSV			have not presented all conti		
	,			factual or legal arguments,	· •	
	Census bed type	•		have we identified all mitiga		
	Residential: 63	·•		factors.		
	Total: 63					
	Census payor ty	pe:				
	Other: 63					
	Total: 63					
	Sample: 7					
	These state region	lential findings are cited				
	These state residential findings are cited in accordance with 410 IAC 16.2.					
	in accordance w	11III 410 IAC 16.2.				
	Quality review completed on April 26, 2011 by Bev Faulkner, RN					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

003283

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  00			(X3) DATE SURVEY  COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING		04/20/2	
			B. WING	STREET A	DDRESS, CITY, STATE, ZIP CODE	0 20. 2	
NAME OF P	PROVIDER OR SUPPLIER				S HWY 31 S		
VILLAGE	OAKS AT GREENV	WOOD		INDIANA	APOLIS, IN46227		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		REFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
TAG R0036	(k) The facility must resident's physici representative whe (1) a significant dephysical, mental, of (2) a need to alter is, a need to discontreatment due to a commence a new Based on record revinterview, failed to estimate thanges in bruises, and of unknown communication physician for 2 of 7 reviewed in the facility of the facility	est immediately consult the fan and the resident's legal en the facility has noticed: solve in the resident's for psychosocial status; or treatment significantly, that notinue an existing form of dverse consequences or to form of treatment.  Observation,  riew and the facility  nsure  t weight loss,  n condition,  nd a skin tear  vn origin were eated to the and/or families	R003		I. Resident #44's physician made visits to the resident twice during the identified time period, 12/14/10 and 3/3/11, and visits are documented in the resident record. Resident's family and physician were notified of significant weight loss for this time period on 5/9/11. Resider #48's physician was notified of the significant weight loss between 3/2011 and 4/2011 or 5/6/2011. Resident's #48's ski discolorations are resolved. II. Resident weights for the memory care neighborhood were reviewed by the Resident Care Director by April 30 2011. Four other residents were affected by the alleged deficien practice. Physicians, families, at dietician were notified. Dieticiar has schedule a visit for 5/25/11 Skin checks for current resider were completed on 5/10/11 and no other residents were affected.	t nor I t nd n  nts d	DATE 05/16/2011
	D: 1: :	1 1 1			III. Staff will be in-servic on 5/16/2011 by the RCD on monthly weight policies and	ea	
	Findings i	ncluded:			procedures, completing the		

003283

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  00			(X3) DATE SURVEY  COMPLETED	
			B. WIN			04/20/2011	
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	ROVIDER OR SULTEEN	· ·		1	S HWY 31 S		
VILLAGE	OAKS AT GREEN	WOOD		INDIAN	IAPOLIS, IN46227		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTIO	(X5)	
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP	RIATE	N
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	DATE	
					Weight logs monthly, event		
	1 Tl1:	: - 1 1 C			management including discolorations of unknown o	riain.	
	1. The cili	nical record for			family and physician notifica	· .	
	Resident #	# 44  was			and significant changes in s	atus.	
					IV. The RCD and/or	_	
	reviewed	on 4/19/11 at			designee will be responsible	l l	
	11.20 0 22	. The resident			sustained compliance. The F and/or designee will review		
	11.30 a.III	. The resident			memory care weights month	ıly	
	was admit	tted on			and appropriate notifications	<b>I</b>	
					be made for significant weig	<b>I</b>	
	4/13/2008 and currently				changes, and documented in resident record. The RCD a	I	
	resides on	the Memory			designee will audit the mem	·	
		•			care weights monthly for	/	
	Care unit.				compliance and present aud	it	
					results to the QA Committee	<b>I</b>	
					The RCD and/or designee w review event management		
	Diagnoses	s included, but			reports upon receiving them	to	
		ŕ			identify any injuries of unkn	l l	
	were not l	imited to,			origin and will initiate an		
	hunartanc	ion, dementia,			investigation upon receiving	I	
	hypertens	ion, ucmenta,			information. Injuries of unk origin will be reported to Ind		
	coronary a	artery disease,			State Department of Health	I	
					required per regulations. The	<b>I</b>	
	osteoarthr	ritis, chronic			RCD and/or designee will re	I	
	obstructiv	e pulmonary			5 records at random on a w basis to sustain compliance.	· •	
		1			audit results will be presented	I	
	disease, le	eft hip fracture			the QA committee. The QA		
	and urinar	ry tract			committee will determine if		
		y naci			continued auditing is necess	• • • • • • • • • • • • • • • • • • •	
	infection.				based on 2 consecutive qua of sustained compliance. The	l l	
					Regional Team will monitor	I	
					random during routine visits	I	
					during the Annual Comprehe	ensive	
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID:	9HXV11	Facility	ID: 003283 If continuation	n sheet Page 3 of 45	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	NSTRUCTION 00	COMPI	LETED	
			B. WIN		DDDESG CITY GTATE TO CORE	04/20/2	2011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE S HWY 31 S		
VILLAGE	OAKS AT GREEN	WOOD		INDIAN	APOLIS, IN46227		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	Е	(X5) COMPLETION DATE
	The facility	ty weight log			Process Review.		
	was review	wed on 4/19/11					
	and indica	ated the					
	weights fo	or Resident #					
	44 were as	s follows:					
	1/2011 - 1	47 pounds,					
	2/2011 - n	o weight					
		3/2011 - 128					
	pounds. T	he log					
	indicated	this was a 13%					
	decrease i	n weight from					
	January to	March.					
		policy, titled					
		Monitoring,"					
	_	ded by the					
		Director on					
		12:02 p.m.,					
	included,	but was not					
	limited to	the following:					
				ļ			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE  A. BUILDING  B. WING	00	CON	TE SURVEY MPLETED 0/2011	
	PROVIDER OR SUPPLIER		STREI 7212	ET ADDRESS, CITY, STATE, 2 LUS HWY 31 S ANAPOLIS, IN46227	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	"Weight					
	LossResidents shall be					
	weighed a	t least monthly				
	to determi	ne whether				
	they have	significant				
	weight los	ss: 5.0% in one				
	month, 7.5	5% in three				
	months, o	r 10% in six				
	monthsI	Report				
	significan	t weight loss to				
	the attend	ing physician				
	and family	y/responsible				
	party; imp	olement				
	appropriat	te interventions				
	with phys	ician's				
	recommen	ndationsMem				
	ory Care o	onlyAll				
	residents	will be				
	weighed r	nonthlyIf				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLI	E CONSTR 0		(X3) DATE S COMPL		
			A. BUILDING B. WING			04/20/2	011
NAME OF I	PROVIDER OR SUPPLIER		l		ESS, CITY, STATE, ZIP CODE  WY 31 S		
VILLAGE	OAKS AT GREEN	WOOD			DLIS, IN46227		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	,	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CF	ROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
	there is m	ore than a 5					
	pound var	riance from					
	resident's previous						
	weight, ch	neck scale for					
	accuracy a	and					
	reweigh	Maintain					
	Weight Lo						
	resident's	record"					
	Nursing n	otes from 12/					
		nrough 3/3/11					
	did not inc	_					
		on of the weight					
		physician or					
	family.						
	<b>.</b>	, 1 , 1					
		otes, dated					
	12/13/10 a	at 7:00 p.m.					
	indicated,	" the					
	resident w	as lethargic.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE  A. BUILDING  B. WING	00	li i	e survey Pleted //2011	
	PROVIDER OR SUPPLIER		7212	T ADDRESS, CITY, STATE, ZIP ( US HWY 31 S ANAPOLIS, IN46227	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	B/P (bloo	d pressure)				
	88/56Sp	eech				
	somewhat	t slurred. CNAs				
	(certified	nurse				
	assistants	) had to wheel				
	chair back	cward as				
	resident w	ouldn't pick				
	her feet u	pHospice				
	stated to p	out her in bed				
	and they v	would be out				
	first thing	in the				
	morning	."				
	There was	s no indication				
		sing notes the				
		•				
	pirysician	was notified.				
	During an	interview with				
	the Reside	ent Care				
	Director of	on 4/19/11 at				

	OF CORRECTION	IDENTIFICATION NUMBER:		ULTIPLE CO.	NSTRUCTION 00	COMPI	
			B. WIN			04/20/2	011
NAME OF I	PROVIDER OR SUPPLIER	<u>-</u>			ADDRESS, CITY, STATE, ZIP CODE S HWY 31 S		
VILLAGE	OAKS AT GREEN	WOOD	INDIANAPOLIS, IN46227				
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE
	5:15 p.m.,	, she indicated					
	she could	find no					
	document	ation of					
	interventi	ons or					
	physician	notification of					
	the signifi	cant weight					
	loss. She stated, "To my						
	knowledg	e, there is					
	none" S	he indicated					
	the dietary	y log from the					
	Registered	d Dietician did					
	not indica	te any referrals					
	in March,	2011 for					
	weight los	ss. Regarding					
	the change	e of condition					
	of Reside	nt # 44 on					
	12/13/10,	the Resident					
	Care Dire	ctor indicated					
	there was	no					
	document	ation that the					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CO	NSTRUCTION 00	(X3) DATE S COMPL		
			A. BUILDING B. WING			04/20/2	
NAME OF F	PROVIDER OR SUPPLIER	<b>!</b>			DDRESS, CITY, STATE, ZIP CODE		
VILLAGE	OAKS AT GREEN	WOOD	I .		S HWY 31 S APOLIS, IN46227		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	- 1	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
	physician	had been					
	notified.						
	2. The clinical record for						
	Resident #	# 48 was					
	reviewed	on 4/19/11 at					
	09:45 a.m	. The resident					
	was admit	tted on 3/31/06					
	and currer	ntly resides on					
	the Memo	ory Care unit.					
	Diagnoses	s included, but					
	were not l	imited to,					
	dementia,	anxiety,					
	aspiration	risk,					
	•	ion, ischemic					
	vascular d	ŕ					
	hyperlipid	,					
	osteoporo						
	osteoarthr						
	USICUAL IIII	1015.					
	l			-			

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COM	TE SURVEY  IPLETED  1/2011
	PROVIDER OR SUPPLIER		7212 U	ADDRESS, CITY, STATE, ZIP CO S HWY 31 S IAPOLIS, IN46227	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
		ty weight log				
		wed on 4/19/11				
	and indica					
		f Resident # 48 ollows: 1/2011 -				
		ds, 2/2011 - no				
	1	corded, 3/2011				
		nds, 4/2011 -				
	133 pour	ŕ				
	•	of 137 pounds,				
		a significant				
	_	ss of 10% from				
	March to					
		1				
	During an	interview with				
	the Reside	ent Care				
	Director of	on 4/19/11 at				
	5:10 p.m.,	, she indicated				
	there was	no				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			BB10	00	COMPL	SURVEY ETED
		- 1			04/20/2	011
OVIDER OR SUPPLIER		·			•	
DAKS AT GREENV	VOOD					
			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
	,		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
documenta	ation or					
physician	notification of					
the significant weight						
loss for Re	esident # 48.					
She indica	ited she					
thought the March						
weight of 153 pounds						
may have	been an error,					
but no rew	eight was					
done. She	indicated the					
Registered	l Dietician log					
did not inc	clude a weight					
loss referra	al for Resident					
# 48.						
Nursing no	otes, dated					
1/6/2011 a	at 9:30 p.m.					
	•					
	or resident s					
	Summary ST (EACH DEFICIENCE REGULATORY OR I documental physician the significal thought the weight of may have but no rewelled to the But no rewelled to the But no rewelled to the But no rewelled to the But no rewelled to the Harmonia to	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  documentation or physician notification of the significant weight loss for Resident # 48.  She indicated she thought the March weight of 153 pounds may have been an error, but no reweight was done. She indicated the Registered Dietician log did not include a weight loss referral for Resident	DOVIDER OR SUPPLIER DAKS AT GREENWOOD  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  documentation or physician notification of the significant weight loss for Resident # 48.  She indicated she thought the March weight of 153 pounds may have been an error, but no reweight was done. She indicated the Registered Dietician log did not include a weight loss referral for Resident # 48.  Nursing notes, dated 1/6/2011 at 9:30 p.m. indicated, "writer informed of "bruise" in	DOVIDER OR SUPPLIER DAKS AT GREENWOOD  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  documentation or physician notification of the significant weight loss for Resident # 48. She indicated she thought the March weight of 153 pounds may have been an error, but no reweight was done. She indicated the Registered Dietician log did not include a weight loss referral for Resident # 48.  Nursing notes, dated 1/6/2011 at 9:30 p.m. indicated, "writer informed of "bruise" in	DAKS AT GREENWOOD  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  documentation or physician notification of the significant weight loss for Resident # 48.  She indicated she thought the March weight of 153 pounds may have been an error, but no reweight was done. She indicated the Registered Dietician log did not include a weight loss referral for Resident # 48.  Nursing notes, dated 1/6/2011 at 9:30 p.m. indicated, "writer informed of "bruise" in	DOUDER OR SUPPLIER DAKS AT GREENWOOD  SUMMARY STATEMENT OF DEFICIENCIES (FACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR I.S. (IDENTIFYING INFORMATION))  documentation or physician notification of the significant weight loss for Resident # 48.  She indicated she thought the March weight of 153 pounds may have been an error, but no reweight was done. She indicated the Registered Dietician log did not include a weight loss referral for Resident # 48.  Nursing notes, dated 1/6/2011 at 9:30 p.m. indicated, "writer informed of "bruise" in

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL' A. BUILD B. WING		NSTRUCTION  00	(X3) DATE S COMPL 04/20/2	ETED
	PROVIDER OR SUPPLIER			7212 US	DDRESS, CITY, STATE, ZIP CODE S HWY 31 S APOLIS, IN46227	ı	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	chest. Dis	coloration is					
	about the	size of a 1/2					
	dollarNurse notified"						
	There was	s no					
	document	ation in the					
	nursing no	otes that					
	indicated	the family or					
	physician	was notified of					
	this incide	ent.					
	Nursing n 12/16/10 a indicated, (Resident reported r skin tear of applied Ba put a Band tear, will of	otes, dated at 5:00 p.m.,					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  04/20/2011		
	PROVIDER OR SUPPLIER			7212 US	DDDRESS, CITY, STATE, ZIP CODE S HWY 31 S APOLIS, IN46227	1	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)			ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	document	ation in the					
	nursing no	otes indicating					
	the family	or physician					
	was notifi	ed of the					
	incident.						
	Nursing n						
	11/5/2010 at 9:50 a.m.						
	indicated,	"Hospice					
	CNA info	rmed staff of					
	discolorat	ion on right					
	inner fore	arm. Upon					
	assessmer	nt right inner					
	upper fore	earm					
	discolorat	ion 7 cm					
	(centimete	ers) by 4 cm.					
	Red a littl	e yellow dark					
	brown. Al	lso noted right					
	inner low	er forearm 4					
	cm by 7 c	m purple with					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  04/20/2011		
	PROVIDER OR SUPPLIER		STREE 7212	T ADDRESS, CITY, STATE, ZIP COD US HWY 31 S NAPOLIS, IN46227	DE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	red inside	"				
	_	document,				
		illed Nursing				
	Facility - Managem					
		ovided by the				
	, ,	20/11 at 12:02				
		ided but was				
	not limite					
	following	•				
	initiated for that result of Unknown DNS (Dir	investigation is or all incidents ed in an Injury wn Origin. ector of ervices) files				
	report wit	h the				
	Ombuasn	nan and DPH				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU A. BUIL B. WING	LDING	NSTRUCTION 00	(X3) DATE COMPI 04/20/2	LETED	
NAME OF F	PROVIDER OR SUPPLIE	R	•		ADDRESS, CITY, STATE, ZIP CODE	-	
VILLAGE	OAKS AT GREEN	IWOOD			S HWY 31 S APOLIS, IN46227		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE
	for Unusu	ual Occurrences					
	within 24	hours of					
	knowledg	ge of the					
	eventD	NS gives Event					
	Managem	nent Report to					
	Administrator for review						
	and signatureLicensed						
	Staff who Assessed						
	Resident	shall notify					
	family &	call					
	Physician	Licensed					
	Staff shal	l continue to					
	evaluate 1	resident for					
	possible o	change in					
	condition	, notify					
	physician	and family"					
		-					
	A facility	document,					
	titled "Ev	ent					
	Managem	nent Report,"					

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COMPLETED 04/20/2011
NAME OF F	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE, ZIP CODE S HWY 31 S	
VILLAGE	OAKS AT GREENWOOD	INDIAN	APOLIS, IN46227	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
	reviewed in the presence			
	of the Resident Care			
	Director on 4/20/11 at			
	4:05 p.m., indicated the			
	physician was notified of			
	the 11/5/2010 incident,			
	but there was no			
	documentation the			
	family was notified.			
	When asked if the			
	incident was reported to			
	Indiana State			
	Department of Health			
	she stated, "I don't think			
	so, but I can't say for			
	sure."			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 04/20/2011			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7212 US HWY 31 S INDIANAPOLIS, IN46227				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  COM				
R0216	shall be delineated manual, but at a massessment shall in following: (1) The resident's mental status. (2) The resident's activities of daily life (3) The resident's and semiannually (4) If applicable, the self-administer mental status. (3) The resident's and semiannually (4) If applicable, the self-administer mental status of the evaluation writing and kept in the Based on resident of 7 residers documented admission of the self-admission of the self-admissi	s physical, cognitive, and s independence in the wing. s weight taken on admission thereafter. The resident's ability to dications. It is shall be documented in the facility. The cord review and the facility failed the weights for 2	R0216	I. Resident #65 no longer resides in the communi Resident #3's weight was obtained and documented in the resident record.  II. An complete aud was completed on 5/3/11 to determine no other residents were affected by the alleged deficient practice.  III. Staff will be in-serviced on 5/16/11 regarding the protocols for obtaining a	ty. he		

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMP 04/20/2	LETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7212 US HWY 31 S INDIANAPOLIS, IN46227				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE	
TAG	65, # 3).  Findings in 1. The clim Resident # on 4/20/11 resident was 12/1/10 and another factor of the control	ical record for 65 was reviewed at 5:30 p.m. The as admitted on d transferred to eility on 2/14/11.  included, but mited to, topenic disorder, cognition, and rosacea.	TAG	weight for residents being admitted or re-admitted.  IV. The RCD will responsible for sustained compliance. The RCD and designee will complete a raudit for admissions or re-admissions within 72 he admission to ensure susta compliance. Audit results presented to the QA committee will deif continued auditing is ne based on 2 consecutive quof sustained compliance. Regional Team will monitor random during routine vis during the Annual Compre Process Review.	be  I/or ecord  ours of ined will be nittee. termine cessary uarters The or at	DATE	
		of indicated					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED - 04/20/2011		
	PROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CO IS HWY 31 S NAPOLIS, IN46227	DDE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	there was r	o documentation				
	of a record	ed admission				
	weight.					
	the Resider	n 4/20/11 at 6:55 ndicated she no tion of the weight for				
	2. The clin	ical record for				
		3 was reviewed				
		at 12:48 p.m.				
	on 3/19/11.	nt was admitted				
	UII <i>3/17/1</i> 1.					
	were not li	included, but mited to, deep bosis, diabetes				

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC  A. BUILDING  B. WING	00	COMP 04/20/2	LETED	
	PROVIDER OR SUPPLIER		STREET A 7212 U	ADDRESS, CITY, STATE, ZIP CODE S HWY 31 S IAPOLIS, IN46227	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	D BE	(X5) COMPLETION DATE
	and hypoth The clinicator Resider there was r	levated platelets, ayroidism.  all record review of # 3 indicated no documentation ed admission				
	weight.  During an the Resider Director or	interview with ntial Care n 4/20/11 at 1:00 ndicated she was locate tion of the weight for				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING B. WING	00	COM 04/20	E SURVEY PLETED /2011	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7212 US HWY 31 S INDIANAPOLIS, IN46227			
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
R0243	(3) The individual medication shall of in the individual's records that indica (A) time; (B) name of medic (C) dosage (if app (D) name or initial administering the Based on and intervent facility fathe initial administer were documented by the individual administering the medication of the initial administering the initial administration of the	administering the locument the administration is medication and treatment ate the: cation or treatment; blicable); and is of the person drug or treatment. record review riew, the iled to ensure in medication amented on the cation Record residents in a cation Record resident #  included:  d for Resident	R0243	I. Resident # was reviewed and no oth omissions were noted. In negative effects were no II. A complete was conducted by the RO 5/9/11. No other resident affected by the alleged of practice.  III. The nursing sincluding LPN's and QMA in-serviced on 5/16/11 of medication administratio practices and standards.  IV. The RCD is refor sustained compliance. RCD and/or designee will resident records at randoweekly basis to monitor compliance. The audit resident records at randoweekly basis to monitor compliance. The audit resident records at randoweekly basis to monitor compliance. The Region will determine if continue need to be presented, base consecutive quarters of seconsecutive quarters of seconsecutive quarters of seconsecutive and during Annual Comprehensive P	ner No ted. MAR audit CD on ts were deficient  staff, 's, will be n n esponsible The I audit 5 om on a esults will ommittee de results ased on 2 sustained al Team uring the	05/16/2011
	# 60 was :	reviewed on		Review.		

003283

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO  A. BUILDING  B. WING	00	li i	E SURVEY PLETED (2011	
	PROVIDER OR SUPPLIEF		7212 U	ADDRESS, CITY, STATE, ZIP CO S HWY 31 S IAPOLIS, IN46227	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	4/20/11 at	: 11:30 a.m.				
		s included, but				
	were not l	imited to,				
	dementia,	anxiety,				
	confusion	, hypertension,				
	osteoarthritis, coronary					
	artery disease, weakness,					
	hyperlipic	lemia, diabetes				
	mellitus, a	and				
	gastroeso	phageal reflux				
	disease.					
	The Medi	cation				
	Administ	ration Record,				
	dated Janu	uary, 2011,				
	included,	but was not				
	limited to	, the following				
	dates, whi	ich had no				
		cumented to				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC  A. BUILDING  B. WING	00	(X3) DATE COMP 04/20/2	LETED	
	PROVIDER OR SUPPLIEF		7212 U	ADDRESS, CITY, STATE, ZIP CODE S HWY 31 S APOLIS, IN46227	•	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
	indicate n	nedications had				
	been adm	inistered.				
	inhale 1 p times a da January 1 10, 12, 13 18. Norvasc 5 tablet - gir orally onc - January 10, 12, 13 17, 18, 25 Aspirin 32 tablet - gir orally 2 ti a.m.: - Jan	0-50 Diskus - uff by mouth 2 ny: 6 a.m 1, 4, 5, 6, 7, 9, 14, 15, and milligram we 1 tablet he a day: 5 a.m.: 1, 4, 5, 6, 7, 9, 14, 15, 16, 14, 15, 16, 15 milligram we 1 tablet mes a day: 5 nuary 1, 4, 5, 6, 3, 14 and 18.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED - 04/20/2011		
	PROVIDER OR SUPPLIER		7212	T ADDRESS, CITY, STATE, ZIP CO US HWY 31 S ANAPOLIS, IN46227	DDE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE AF DEFICIENCY)	RENCED TO THE APPROPRIATE	
	Carvedilo	1 12.5				
	milligram	tablet - give 1				
	tablet oral	ly 2 times a				
	day: 5 a.m	n January 1,				
	4, 5, 6, 7,	9, 12, 13, 14,				
	15, and 18	3.				
	Colace 10	0 milligram				
	capsule - give 1 capsule					
	orally onc	e a day: 5 a.m.				
	- January	1, 4, 5, 6, 7, 8,				
	9, 10, 11,	12, 13, 14, 15,				
	and 22.					
	A policy t	itled				
	"Medicati	on -				
	Profession	nal Practice				
	Guideline	s," dated				
	9/29/10 ar	nd provided by				
	the Reside	•				
	Director of	on 4/19/11 at				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  ND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY  COMPLETED  04/20/2011			
NAME OF PROVIDER OR SUPPLIER  VILLAGE OAKS AT GREENWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 7212 US HWY 31 S INDIANAPOLIS, IN46227					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE COMPLETION			
	5:53 p.m.	included, but						
	was not li	mited to, the						
	following	: :						
	"Docum	nentation that						
	the medication has or has							
	not been							
	administered/assisted							
	will be en	tered on the						
	Medication	on						
	Administi	ration/Observat						
	ion Recor	dStaff						
	responsib	le for						
	medicatio	n assistance						
	will audit	prior shift's						
	MARs to	ensure that						
	there are 1	no missed						
	initials or	omissions"						
	In an inter	rview on						

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			00	(X3) DATE SURVEY COMPLETED 04/20/2011
NAME OF I	PROVIDER OR SUPPLIER			raddress, city, state, zip co US HWY 31 S	DE
VILLAGE	OAKS AT GREENW	/OOD		NAPOLIS, IN46227	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE COMPLETION
	4/19/11 at	12:20 p.m.,			
	the Reside	nt Care			
	Director in	idicated that			
	she was no	ot sure which			
	nurse had	completed the			
	Medication	n			
	Administra	ation Record			
	for Resident # 60 in				
	January be	cause she had			
	not been w	orking at the			
	facility du	ring that			
	month. She	e also			
	indicated t	hat as far as			
	she knew,	there was no			
	other docu	mentation			
	available tl	hat would			
	indicate if	the			
	medication	ns had been			
	administer	ed on the days			
	where no i	_			
				1	

	IT OF DEFICIENCIES OF CORRECTION				(X3) DATE SURVEY COMPLETED 04/20/2011
	PROVIDER OR SUPPLIER		7212 U	ADDRESS, CITY, STATE, ZIP CODE S HWY 31 S APOLIS, IN46227	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	been reco	rded or why			
	medication	ns had been			
R0247	shall be noted in the	edication administration ne resident ' s record. The notified of any error in			
	medication adminiactual or potential resident.  Based on and intervious facility faithat medical document given, due on the Me Administration contained	record review iew, the iled to ensure eations ed as not being to being held,	R0247	I. Resident #60's MA was reviewed and no other medications were withheld. No negative effects were noted. Physician notified that the medications were held on 5/12/11.  II. A complete MAR au was conducted by the RCD on 5/9/11. No other residents we affected by the alleged deficier practice.  III. The nursing staff, including LPN's and QMA's will in-serviced on 5/16/11 on medication administration practices and standards, and policies on documentation for refusals or why a medication h	dit re nt be

003283

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  D. WING			(X3) DATE SURVEY  COMPLETED  04/20/2011		
	PROVIDER OR SUPPLIER		B. WING STREET ADDRESS, CITY, STATE, ZIP CODE  7212 US HWY 31 S INDIANAPOLIS, IN46227				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		IID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			ATE	(X5) COMPLETION DATE
	were held	and the facility			not been administered, and physician notification of the		
	failed to e	nsure that the			same.  IV. The RCD is respons	ible	
	physician	was notified of			for sustained compliance. The RCD and/or designee will audi		
	held medi	cations for 1 of			resident records at random or weekly basis to monitor	ıa	
	7 resident	s reviewed in a			compliance. The audit results be presented to the QA	will	
	sample of	7 (Resident #			committee and the QA commi will determine if continued res		
	60).				need to be presented, based of consecutive quarters of sustai		
	   Findings i	ncluded:			compliance. The Regional Tea will monitor at random during routine visits and during the Annual Comprehensive Proces Review.		
	The record	d for Resident					
	# 60 was 1	reviewed on					
	4/20/11 at	11:30 a.m.					
	Diagnoses	s included, but					
	were not l	imited to,					
	dementia,	anxiety,					
	confusion	, hypertension,					
	osteoarthr	itis, coronary					
	artery dise	ease, weakness,					
	hyperlipic	lemia, diabetes					

003283

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  00			(X3) DATE S COMPL	
			A. BUILDING B. WING	G		04/20/2	
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
VILLAGE	OAKS AT GREEN	WOOD			S HWY 31 S APOLIS, IN46227		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TA		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
	mellitus, a	and	İ	İ			
	gastroesop	ohageal reflux					
	disease.						
	The Medication						
	Administr						
	dated Janu						
	indicated						
	medicatio	ns were not					
	given, due	e to being held,					
	as docume	ented by					
	circling th	ie					
	administe	ring nurse					
	initials, fo	or the following					
	dates:						
	Pepsid 20	milligram -					
	•	let orally 2					
		y: 5 a.m					
	January 4,	, 5, 6, 7, 9, 10,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING B. WING	CONSTF 0 —		COI	TE SURVEY MPLETED 0/2011
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7212 US HWY 31 S INDIANAPOLIS, IN46227				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL ROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
	13, 14 and	1 15.					
	Glipizide	5 milligram -					
	give 1 tab	let orally once					
	a day: 5 a	.m January 4,					
	5, 6, 7, 9,	10, 13, 14, 15					
	and 18.						
	Hydrocod						
	acetaminophen 5-325						
	milligram	s - give 1 tablet					
	orally 2 ti	mes a day: 5					
	a.m Jan	uary 4, 5, 6, 7,					
	9, 10, 13,	14, 15 and 18.					
	Lisinopril	20 milligram					
	- give 1 ta	blet orally					
	once a day	y: 5 a.m					
	January 4	, 5, 6, 7, 9, 10,					
	13, 14, 15	and 18.					
	Claritin 10	0 milligrams -					
	give 1 tab	let orally once					
	a day: 5 a	.m January 4,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C  A. BUILDING  B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 04/20/2011	
	PROVIDER OR SUPPLIER		STREET 7212 U	ADDRESS, CITY, STATE, ZIP CODE JS HWY 31 S NAPOLIS, IN46227	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION
		10, 13, 14, 15			
	and 18.				
	Namenda	10 milligrams			
	- give 1 ta	blet orally 2			
	times a da	y: morning -			
	January 4	, 5, 6, 7, 9, 10,			
	13, 14, 15	, 18, 19 and			
	20.				
	Spiriva 18	3 microgram			
	CP Handi	haler - inhale			
	contents c	of 1 capsule			
	orally onc	e daily (by			
	taking 2 s	eparate			
	inhalation	s via			
	handihale	r device): 5			
		uary 4, 5, 6, 7,			
		14, 15 and 20.			
		n-M - give 1			
		lly daily at 5			
		uary 4, 5, 6, 7,			
	w.111. Juli				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU A. BUII		00	COMPI		
			B. WIN			04/20/2	2011
NAME OF I	PROVIDER OR SUPPLIER	2			DDRESS, CITY, STATE, ZIP CODE	•	
VILLAGE	OAKS AT GREEN	WOOD		1	S HWY 31 S APOLIS, IN46227		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
	9, 10, 13,	14, 15, 18 and					
	21						
	The Medi	cation					
	Administr	ration Record					
	for the month of January						
	did not indicate why						
	these medications were						
	held.						
	Nursing n	otes for the					
	_	January did not					
	indicate w	•					
		ns were held					
		ot indicate the					
	-	was notified of					
	held medi	cations.					
	A policy t	itled					
	"Medicati	on -					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
			A. BUILDING B. WING		04/20/2011
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE  JS HWY 31 S	•
VILLAGE	OAKS AT GREEN	WOOD		NAPOLIS, IN46227	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE DATE
	Profession	nal Practice			
	Guideline	s," dated			
	9/29/10 ar	nd provided by			
	the Reside	ent Care			
	Director o	on 4/19/11 at			
	5:53 p.m.	included, but			
	was not limited to, the				
	following:				
	"Docum	entation that			
	the medic	ation has or has			
	not been				
	administe	red/assisted			
	will be en	tered on the			
	Medicatio	n			
	Administr	ration/Observat			
	ion Recor	dStaff			
	responsib	le for			
	_	n assistance			
	   will andit	prior shift's			
	,, iii wooit	F01 511110 5			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE ( A. BUILDING B. WING	00	li i	E SURVEY PLETED /2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7212 US HWY 31 S INDIANAPOLIS, IN46227				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
	MARs to	ensure that					
	there are r	no missed					
	initials or	omissions"					
	In an inter	view on					
	4/19/11 at	12:20 p.m.,					
	the Reside	ent Care					
	Director indicated she						
	was not su	are which nurse					
	had comp	leted the					
	Medicatio	n					
	Administr	ation Record					
	for Reside	ent # 60 in					
	January b	ecause she had					
	not been v	working at the					
	facility du	ring that					
	month. Sh	ie also					
	indicated	that as far as					
	she knew,	there was no					
	other docu	ımentation					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION 00			(X3) DATE SURVEY COMPLETED		
			A. BUILDIN B. WING	NG	<del></del>	04/20/2011	
	ROVIDER OR SUPPLIER		7.	212 US	DDRESS, CITY, STATE, ZIP CODE S HWY 31 S		
	OAKS AT GREENV				APOLIS, IN46227		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	available t	that would					
	indicate if	the					
	medication	ns had been					
	administer	red on the days					
	where no	initials had					
	been recor	rded or why					
the medications had been							
	held.						
R0301	the following:  (A) Resident's ful  (B) Physician's na  (C) Prescription nu  (D) Name and stre  (E) Directions for u  (F) Date of issue a  applicable).  (G) Name and add  filled the prescription  If medication is pareasonable variation	ame. umber. ength of the drug. use. und expiration date (when					
	•	observation	R030	1	I. Medications for residents #5, 7, 36, 29, 15 and		05/16/2011
	and interv	iew, the			24 that did not have date open documentation were discarded		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUII		INSTRUCTION 00	(X3) DATE SURVEY COMPLETED		
			B. WIN			04/20/2011	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7212 US HWY 31 S INDIANAPOLIS, IN46227				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	facility fai	iled to ensure			and re-ordered. Open dates were placed on the new		
		cations, such as			medications. II. A complete audit of		
	eye drops	and eye			medication carts has been routinely conducted since 4/20	· I	
	ointments	, were properly			and most recently confirmed o 5/12/11 by Kimberly Harper,	n	
	labeled wi	ith the "first			RCD, and Nancy Golay, LPN. I other residents were affected I		
	opened" d	ates and the			the alleged deficient practice.  III. The nursing staff,		
	"do not us	se after" dates			including LPN's and QMA's, wil in-serviced on 5/16/11 on	I be	
	for medical	ations with			medication administration practices and standards, include	lina	
	expiration dates				documenting the date opened	-	
	dependant	t upon the date			medications requiring such.  IV. The RCD is responsib		
	the medic	ations were			for sustained compliance. The RCD and/or designee will audit	t 5	
	opened. T	his affected 6			resident records at random on weekly basis to monitor		
	of 61 resid	dents'			compliance. The audit results be presented to the QA	will	
	medicatio	ns that were			committee and the QA Committee will determine if		
	observed	on the facility's			continued results need to be presented, based on 2		
	4 medicat	ion carts			consecutive quarters of sustair compliance. The Regional Tea	I	
	(Residents # 5, # 7, # 36,				will monitor at random during routine visits and during the		
	# 29, # 15	, and # 24).			5		
	Findings i	ncluded:					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C  A. BUILDING  B. WING	ONSTRUCTION  00	СОМ	e survey Ipleted 1/2011			
NAME OF PROVIDER OR SUPPLIER  VILLAGE OAKS AT GREENWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE  7212 US HWY 31 S  INDIANAPOLIS, IN46227					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
	During obmedicatio 4/20/11 at the present and LPN affollowing Resident at Tears - no date. Resident at Gel Drops opened data Resident at Tears - no data at the present at	eservation of a carts on 4:40, and in ace of LPN # 1 # 2 the was observed:  # 5: Artificial first opened  # 7: Genteal 5 - no first		(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE			
	Tears - no	# 29: Artificial first opened no do not use						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  00			(X3) DATE SURVEY COMPLETED		
			A. BUII B. WIN			04/20/2	
NAME OF F	PROVIDER OR SUPPLIER		!	1	ADDRESS, CITY, STATE, ZIP CODE	<u>!</u>	
VILLAGE	VILLAGE OAKS AT GREENWOOD			1	S HWY 31 S APOLIS, IN46227		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	after date	indicated.					
	Resident #	# 15: Patanol					
	0.1% eye	drops - no first					
	opened da	ite.					
	Resident #	<b># 24</b> :					
	Acri-Lube	e S.O.P. Eye					
	Ointment	- no first					
	opened da	ite.					
	A facility	policy titled					
	"Medicati	on -					
	Procedure	es," provided					
	by the Exe	ecutive					
	Director (	ED) on 4/20/11					
	at 12:02 p	.m. included,					
	_	ot limited to,					
	the following:						
	   "All me	dications must					
	be labeled	l. Medication					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  04/20/2011			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  7212 US HWY 31 S  INDIANAPOLIS, IN46227					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	should maintained in							
	accordanc	e with label						
	instruction	ns and						
	applicable	e state and						
	federal reg	gulations.						
	Medicatio	n labels shall						
	include: Residents name,							
	Name of 1	nedication,						
	Strength o	of medication,						
	Expiration	n date"						
	During an interview with the Resident Care Director on 4/20/11 at 4:40 p.m., she indicated she was not sure if the facility used both "first opened date" labels and "do not use after date indicated" labels on							

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  00			(X3) DATE SURVEY COMPLETED				
			B. WING			04/20/2011			
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 7212 US HWY 31 S						
VILLAGE OAKS AT GREENWOOD					APOLIS, IN46227				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		PR	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	medication	ns such as,							
	insulin an	d eye drops.							
	During an	interview on							
	4/20/11 at	5:00 p.m.,							
	with LPN	# 1, she							
	indicated	that medication							
	containers, such as eye								
	drops and	insulin, should							
	be labeled	with both							
	"date first	opened", and							
	"do not us	e after date							
	indicated.	**							
R0302	(6) Over-the-count identified with the (A) Resident name (B) Physician name (C) Expiration date (D) Name of drug.	e. e. e.							
	facility failed to	ation and interview, the ensure that over-the ons were properly labeled	R030	02	I. Over-the-counter Medications for residents #12, 37, 35 and 62 have been labele appropriately.	ed	05/16/2011		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 04/20/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 7212 US HWY 31 S VILLAGE OAKS AT GREENWOOD INDIANAPOLIS, IN46227 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE with the resident name and physician II. A complete audit of medication carts has been name for the over-the counter medications routinely conducted since 4/20/11 for 4 of 61 residents' medications that and most recently confirmed on were observed on the facility's 4 5/12/11 by Kimberly Harper, medication carts (Residents # 12, # 37, # RCD, and Nancy Golay, LPN. No 35, and # 62). other residents were affected by the alleged deficient practice. The nursing staff, Findings included: including LPN's and QMA's, will be in-serviced on 5/16/11 on During observation of medication carts on medication administration 4/20/11 beginning at 4:40 p.m., and in the practices and standards, including presence of LPN # 1 and LPN # 2, the documenting the date opened on following was observed: medications requiring such. The RCD is responsible for sustained compliance. The Resident # 12: Nauzene chewables RCD and/or designee will audit 5 tablets- no resident name, no physician resident records at random on a name. Tylenol 325 milligram tablets - no weekly basis to monitor compliance. The audit results will physician name. be presented to the QA Resident # 37: Acetaminophen 500 committee and the QA milligram caplets - no physician name. Committee will determine if Resident #35: Tylenol 500 milligram continued results need to be tablets - no physician name. presented, based on 2 Resident # 62: Diphenhydramine consecutive quarters of sustained compliance. The Regional Team hydrochloride (Equate Allergy will monitor at random during Medication) - no physician name. routine visits and during the **Annual Comprehensive Process** A facility policy titled "Medication -Review. Procedures," provided by the Executive Director (ED) on 4/20/11 at 12:02 p.m. included, but was not limited to, the following: "...All medications must be labeled. Medication should maintained in

003283

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTI		IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
			B. WING		04/20/2011	
NAME OF P	ROVIDER OR SUPPLIER		1	T ADDRESS, CITY, STATE, ZIP CODE		
VILLAGE	OAKS AT GREEN	WOOD	I	US HWY 31 S ANAPOLIS, IN46227		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
		label instructions and and rederal regulations.				
	• •	s shall include: Residents				
		nedication, Strength of				
	medication, Expi	_				
	mourou, Emp					
	During an intervi	iew on 4/20/11 at 5:00				
	p.m., with LPN #	‡ 1, she indicated that				
	over-the-counter	medication containers				
	should have labe	ls that include resident				
		rug, instructions and				
	dose.					
R0349		st maintain clinical records				
		These records must be				
	maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.					
	Based on a	record review	R0349	I. Resident #3's reco	ord 05/16/2011	
	and interv	iew, the		designated resuscitation status II. A complete record		
	facility fai	iled to ensure		audit is being conducted by the RCD and/or designee to	9	
	that the re	suscitation		determine if any other resident are affected. Any resident four		
	(code) star	tus of a		to be affected will have a designated resuscitation status	;	
	resident w	as designated		documented in the record.  III. The Staff will be		
	in the clin	ical record for		in-serviced on 5/16/11 on obtaining resuscitation status		
				Obtaining resuscitation status		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		00	COMPLETED 04/20/2011		
			B. WING	PDEET A	DDRESS, CITY, STATE, ZIP CODE	04/20/2011		
NAME OF I	PROVIDER OR SUPPLIER				S HWY 31 S			
	VILLAGE OAKS AT GREENWOOD			INDIANAPOLIS, IN46227				
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL			D EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			AG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE		
	1 of 7 resi	1 of 7 residents reviewed			with physician orders upon admission or at any time a			
	for emerge	ency			resident and/or family determing a change in a resuscitation	nes		
	information	on in a sample			status, and documenting the resuscitation status in the			
	of 7 reside	ents (Resident			resident record.			
	# 3).				IV. The RCD is responsible for sustained compliance. The	oie		
	$[\pi \ J].$				RCD and/or designee will audit			
					admission records within 72 hours after admission to monitor	or		
	Findings i	ncluded:			compliance. The audit results			
	1 111611185 1				be presented to the QA			
					Committee and the QA Committee will determine if			
	The clinic	al record for			continued auditing is necessary	l l		
	Resident #	# 3 was			based on 2 consecutive quarter of sustained compliance. The	rs		
	reviewed	on 4/20/11 at			Regional Team will monitor during routine visits and during			
	12:48 p.m	l <b>.</b>			the Annual Comprehensive Process Review.			
	Diagnoses	s for Resident #						
	3 included	l, but were not						
	limited to,	, diabetes						
	mellitus,							
	   hypothyro	oidism, elevated						
	piatelets a	nd deep vein						
	thrombosi	s. The resident						

003283

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
			B. WING		04/20/2011
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE S HWY 31 S	
VILLAGE	VILLAGE OAKS AT GREENWOOD			APOLIS, IN46227	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE
	was admit	ted on 3/19/11.			
	The recap	itulated			
	physician	order sheet for			
	April, 201	1, for Resident			
	# 3 did no	t include an			
	order for e	either full			
	resuscitati	on or no			
	resuscitati	on (DNR).			
	During an	interview with			
	the Reside	ent Care			
	Director o	on 4/20/11 at			
	7:08 p.m.,	she indicated			
	the code s	tatus on the			
	recapitulated physician order sheet had been updated on 4/20/11 and				
	_	erved that the			
		" section had			
	Tuil Couc	section nau			

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC  A. BUILDING  B. WING	00	(X3) DATE SURVI COMPLETED 04/20/2011		
	NAME OF PROVIDER OR SUPPLIER VILLAGE OAKS AT GREENWOOD			ADDRESS, CITY, STATE, ZIP CODE S HWY 31 S APOLIS, IN46227	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE COM	(X5) MPLETION DATE
	been com	pleted with a				
	check ma	rk. She				
	indicated	prior to				
	4/20/11, t	here was no				
	code statu	is designated				
	on the rec	apitulated				
	physician order sheet for					
	Resident	# 3.				